BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
IRVIN H. STRUB, M.D.	)	File No. 09-2004-160393
Physician's and Surgeon's Certificate No. C 14061	)	
Respondent	)	

DECISION

The attached **Proposed Decision** is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on May 9,2007

IT IS SO ORDERED April 9, 2007 .

MEDICAL BOARD OF CALIFORNIA

By: _____

Barbara Yaroslavsky
Chair
Panel B
Division of Medical Quality

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: IRVIN H. STRUB, M.D. 1109 Deborah Street Upland, CA 91784 Physician's and Surgeon's Certificate No. C14061 Respondent.	Case No. 09-2004-160393 OAH No. L2005120052

PROPOSED DECISION

Administrative Law Judge David L. Benjamin, State of California, Office of Administrative Hearings, heard this matter in Riverside, California, on November 1, 2, and 3, 2006, and February 2 and 14, 2007.

Steven H. Zeigen, Deputy Attorney General, represented complainant David T. Thornton, Executive Director of the Medical Board of California, Department of Consumer Affairs.

Frank Albino, Attorney at Law, Parker, Milliken, Clark, O'Hara & Samuelian, 333 South Hope Street, 30th Floor, Los Angeles, California 90071-1488, represented respondent Irvin H. Strub, M.D., who was present throughout the hearing.

The matter was submitted on February 14, 2007.

FACTUAL FINDINGS

1. On July 11, 1952, the Medical Board of California (board) issued Physician's and Surgeon's Certificate No. C 14061 to respondent Irvin H. Strub, M.D. On July 25, 2005, complainant David T. Thornton, acting in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed an accusation against respondent's certificate. Respondent filed a notice of defense. The matter was submitted on the second amended accusation, dated December 4, 2006.

2. In 2003, respondent was hired as a per diem physician at the Kaiser Permanente Medical Center in Riverside. He had retired from his practice in Chicago and moved to California with his wife. Respondent wanted to continue working, at least part-time.

3. On June 22, 2004, respondent was scheduled to perform a flexible sigmoidoscopy on F.L.M., a 64-year-old female patient. F.L.M. presented for examination. Licensed Vocational Nurse Sylvia Torres assisted respondent. One of Torres's responsibilities during a sigmoidoscopy is to watch a monitor that displays the images captured by the scope. From where Torres was positioned during the procedure, she could not see the physical insertion of the instrument. When the images from the scope appeared on Torres's monitor, however, they did not look like colon. There was no movement of layers as she normally saw in the mucosa, and the area would not open up to let the scope go through. Based upon a procedure she had seen many years earlier, Torres concluded that she was looking at vaginal tissue and cervix, and that respondent had inserted the scope into the vagina. The scope came out of the patient and, when respondent reinserted it, Torres saw the same images she had seen the first time. She did not say anything to respondent; she "wrestled with it," but she did not know how to say it.

Respondent took three photographs through the sigmoidoscope during the procedure.

After the procedure, respondent ordered a CEA test (a test for colon cancer) and directed Torres to schedule F.L.M. for a colonoscopy. Torres administered the blood test and scheduled F.L.M. for a colonoscopy two days later, on June 24, 2004.

After the procedure, Torres told her supervisor and a senior technician that she thought respondent had scoped F.L.M.'s vagina.

4. After the procedure on June 22, and before respondent saw the next patient, he wrote entries on F.L.M.'s chart and dictated his notes of the procedure. Respondent's written notes state:

> flex sig only to approx 20 cm. [Several] suggestive polyps were observed plus narrowing. (Pt states she had diarrhea) Suggest colonoscopy [with] better prep + CEA to drawn [sic] today.

The transcription of respondent's dictated notes, which was added later to F.L.M.'s chart, states:

> PREPROCEDURE DIAGNOSIS: DIARRHEA
>
> POSTPROCEDURE DIAGNOSIS: INCOMPLETE EXAMINATION

PROCEDURE IN DETAIL: Unfortunately, there had been quite an emergency going on here in the laboratory, so the patient had to wait several hours after preparation. She did admit to having diarrhea. Nevertheless, the flexible sigmoidoscope was passed to only approximately 20 cm. At this point, there appeared to be the suggestion of several polypoid lesions. The mucosa seemed to narrow down, as well. There was, as mentioned, diarrhea which could not be completely removed. In view of the above, it was strongly suggested that the patient undergo a colonoscopy with better preparation from above. A CEA is to be drawn today.

5. James Chain-Chi Wang, M.D., performed the follow-up colonoscopy on F.L.M. on June 24, 2004. Dr. Wang is board certified in internal medicine and gastroenterology. He has been the Chief of Gastroenterology at Kaiser Riverside since 1989. Torres assisted Dr. Wang with the colonoscopy.

Except for the presence of a few diverticula, Dr. Wang's examination of F.L.M.'s colon was normal. He did not find any polypoid lesions, and he did not find any narrowing of the mucosa. F.L.M.'s CEA test was also normal. Dr. Wang took four photographs during the course of the procedure. The images from his procedure are different in appearance than the images from respondent's procedure.

6. After the colonoscopy on June 24, Torres informed Dr. Wang that she thought respondent had inserted the sigmoidoscope into the patient's vagina, not the rectum. Dr. Wang compared the photographs of respondent's procedure with the photographs from his own, compared his findings on examination with respondent's findings, and came to the conclusion that respondent had scoped the patient's vagina. In Dr. Wang's opinion, the photographs from respondent's procedures do not look like colon.

7. Dr. Wang discussed his findings with Adam I. Chen, M.D. Dr. Chen is board certified in internal medicine and gastroenterology, and has been employed by Kaiser Riverside since 1997. Dr. Wang asked Dr. Chen to review respondent's chart and do a "quality control" review. Dr. Chen reviewed respondent's handwritten chart notes and photographs. Dr. Chen also came to the conclusion that respondent had scoped F.L.M.'s vagina. After an internal investigation, Dr. Wang and Dr. Chen decided to terminate respondent's services.

8. Dr. Chen met with respondent on or about July 6, 2004, and informed respondent that his services were being terminated. Respondent asked why, and Dr. Chen told respondent that he had "scoped the wrong area." Respondent replied, "Everyone does that sometimes," and Dr. Chen responded, "Yes, but we know where we are." It was Dr. Chen's impression that respondent had not recognized that he was in the vagina, because there was nothing in respondent's chart to indicate that he had scoped the vagina.

9. On August 4, 2004, the medical director for the Southern California Permanente Medical Group filed a Health Facility Reporting Form (an "805" report) with the board, stating that it had terminated respondent's services and stating its conclusion that, on June 22, 2004, respondent had placed a sigmoidoscope in a patient's vagina. Kaiser's 805 report did not identify F.L.M. by name.

10. When it received Kaiser's 805 report, the board opened an investigation. It issued a subpoena to the Southern California Permanente Medical Group for all medical records related to respondent, including the names and addresses of any potential witnesses to respondent's alleged misconduct. In cases initiated by an 805 report, however, it is the board's practice to inform the medical provider that "patient identifying information" may be redacted. The board so informed Kaiser, and the records Kaiser presented to the board redacted F.L.M.'s name.

11. On March 24, 2005, respondent appeared at the board's offices in San Bernardino for a tape-recorded physician interview. Present for the interview were Jerry Wu, M.D., District Medical Consultant, board investigator Veronica M. Alva, and a person identified only as "Dr. Dieter" from "Kaiser Legal." The interview focused on the June 22, 2004, flexible sigmoidoscopy of F.L.M.

Respondent stated that he saw the patient in the morning after a lengthy delay. He described a patient who was poorly prepared for a flexible sigmoidoscopy. Respondent stated that, after he arrived in the examination room, he had to wait for the patient to emerge from the bathroom and that, as he was preparing to perform the examination, "stool was still coming out." He stated that the instrument went in "very, very easily, and there was so much stool there, there was stool on my hand. I kept flushing in water and aspirating and I have to be honest with you. I've done over 2,000 colonoscopies and this just didn't seem – I'm not the world's greatest, but I've had a little experience at doing these things. Like the normal landmarks just did not seem to be there."[1]

Respondent continued, "I could not see exactly where I was going, and I finally decided – and to be truthful about it, I was even afraid that it might be cervix. I could not say for sure. And I did not dictate that because I was a little embarrassed to be truthful about it."

Dr. Wu told respondent, "Well, you know when I saw the pictures that you took, my first impression was that it was the cervix." Respondent replied, "Yeah. Well, to be truthful about it, I thought it was too, and I was a little embarrassed to write that down."

Alva asked, "So when you did the procedure, there was a possibility that you were entering the vagina rather than the rectum?" And respondent replied, "After I did the

[1] In the first 20 centimeters after a sigmoidoscope is inserted into the rectum, the physician expects to see the dentate line between the anus and rectum, the valve of Houston, and the first muscular fold of the sigmoid colon.

procedure and got up there. . . . I'm not going to say I realized that immediately or I'd have stopped right there. But there was no question about that."

Dr. Wu asked respondent if, at age 83, he felt he still had the dexterity to continue working and respondent replied, "Well, I think I do. Just because I went in the wrong area, I don't think that has anything to do with my dexterity."

Dr. Wu stated, "You're not contesting against Kaiser for –" and respondent replied, "Oh, I can't contest. I mean I made a mistake. I admitted that. In fact the day that they talked to me like that, I said I did make a mistake. I admitted it, you know, and tried explaining this, and they wouldn't even let me talk. Just – I left my coat, my beeper, my badge, everything, and just left and came home and told my wife, honey, I've been dumped."

12. The board filed its accusation against respondent four months later, in July 2005. At the time the board filed its accusation, neither the board nor respondent knew F.L.M.'s name, and the patient's name was still not known when the administrative hearing began on November 1, 2006. Respondent moved to continue the hearing to allow him to pursue efforts, through his civil case against Kaiser,[2] to identify the patient and call her as a witness. Respondent's motion was taken under submission.

13. At hearing in November 2006, respondent testified that, on June 22, 2004, he inserted the sigmoidoscope into the patient's rectum, and denied that he ever inserted the instrument into her vagina. Respondent gave the following account of the procedure:

Respondent was scheduled to work in the morning. The patient in question was the third flexible sigmoidoscope that was scheduled for that morning, and respondent had already done two. He was then informed that other staff members needed his procedure room for an emergency, so the patient was kept waiting for one and one-half hours. Respondent finally saw her between 10:30 a.m. and 11:00 a.m.

Respondent testified that the patient should have been prepared with tap water enemas but, when he entered the procedure room, she was having bowel eliminations and she was in the toilet. She came out of the bathroom and lay down on the table. After the patient was placed on the examination table, respondent asked her if she had any questions, and then she had to go to the bathroom again. Respondent asked the nurse whether this was the best day to do the procedure, since the patient was having "active diarrhea"; there was stool on the examining table and on the patient's gown. The patient said, "I've been taking enemas since January – if you don't do it now, I'll never come back." The nurse said, "Why don't we try it?" and respondent started the procedure.

Respondent stated that there was so much stool that he had to keep flushing and aspirating. He could not visualize anything to give the patient "some type of diagnosis." He could not see the mucosa because there was too much stool. He put the scope in 20

[2] Respondent has filed suit against his former employer for wrongful termination.

centimeters, cleared the stool, took pictures and "I decided to quit right then." Respondent said that he told the patient that he was terminating the procedure early and that he could not see the mucosa. Respondent denied that he terminated the procedure because he could not push the scope in any farther. He testified that he could have gone farther, but he was not comfortable doing so because he could not see too much and did not want to go farther. Respondent testified, "I know I did not put [the scope] in the vaginal canal." Rather, he stated, "I inserted the scope 20 centimeters into the rectum." Respondent testified that he only inserted the scope once.

Respondent testified that he never told Torres to schedule the colonoscopy on an urgent basis. According to respondent, F.L.M. asked him when the colonoscopy would be and respondent told her, "No hurry, but since you're partially prepared, sooner might be easier." Respondent stated that Torres did the scheduling, not him. He was "amazed" that the colonoscopy was scheduled so quickly.

Respondent addressed his statements in the physician interview. Regarding his statement that the normal landmarks did not appear to be there, respondent testified that he does not remember what he meant by that. With respect to his statement that he was "even afraid that it might be cervix," and that he did not dictate that because he was "a little embarrassed," respondent testified that Dr. Chen and others had told him that he was in the vagina and he "began to worry" that he had gone into the vagina; he added that, "as I sit here today [November 3, 2006], I do not think I scoped the vagina." Regarding his statement that "I thought it was [cervix] too, and I was a little embarrassed to write that down," respondent testified that he does not know what he meant by that. He denied that he performed a vaginal examination, and denied that he failed to document a vaginal examination because of embarrassment. And, as to his statement, "Oh, I can't contest. I mean I made a mistake," respondent testified that the mistake he was referring to was performing the sigmoidoscopy at all on a patient who was so poorly prepared.

14. Torres has been a GI Tech in the gastroenterology department at Kaiser Riverside for over 17 years. She knows respondent, and considers herself to be a friend. Torres's husband, a Kaiser physician, works with respondent's son, who is a physician at Kaiser Fontana.

Torres testified that F.L.M.'s procedure was scheduled for the afternoon, not the morning. She does not remember that F.L.M.'s procedure was preempted by an emergency, nor does she remember any discussion of canceling F.L.M.'s examination due to poor preparation. Torres does not remember F.L.M. being poorly prepared for the procedure.

Torres stated that, as she watches the monitor during a flexible sigmoidoscopy, she usually she sees "the colon open, using water or air." In F.L.M.'s case, however, the area did not open and respondent could not pass the scope any farther. The images did not look like any colon she had ever seen. At first, Torres did not think she was looking at cervix, but then the scope could not be moved, and there was "no movement of layers like mucosa." Torres had seen the same thing over 17 years earlier. She came to the realization that she was

looking at vaginal tissue and cervix. Torres then saw the scope fall out; respondent reinserted it and she saw the same images again on the monitor. As Torres put it, she saw "cervix again." Torres testified that respondent has a very good bedside manner, but his demeanor changed during the procedure. He appeared to be concerned that "about what he was seeing," because he could not "open up the area . . . it would not open to let the scope through." When respondent terminated the procedure, Torres felt that respondent "could not go any farther with the scope." There was no fecal matter in the images Torres saw on the monitor.

Torres testified that she remembers leaving the examination room for less than a minute to find another physician, but could not find anyone "because it was a Tuesday afternoon"; Torres did not explain why there were no other physicians in the department on Tuesday afternoons. It is Torres's memory that respondent asked her to find someone to help.

After the procedure, Torres testified, respondent asked her to arrange a colonoscopy "right away . . . soon." It was her impression stated that respondent wanted the colonoscopy done urgently.

Torres testified that, while she was preparing F.L.M. for the colonoscopy, she asked F.L.M. if she had any desensitivity in the vaginal area. According to Torres, F.L.M. told her that "she does not feel much" in the perineal area.

15. Respondent testified that Torres's testimony did not affect his memory of the examination of F.L.M. He reiterated that the procedure was performed on a Tuesday morning. Respondent is confident that the patient had active diarrhea and that he saw semi-solid stool during the examination that he could not aspirate. He testified that F.L.M. did not just use the bathroom before the examination, like most patients do, but that she used the bathroom two to three times. Respondent denied sending Torres out of the examination room, and stated that he would never do that while attending to a female patient.

16. At the conclusion of the first three days of hearing, respondent's motion for a continuance to call the patient as a witness was granted. Respondent identified F.L.M. through his civil case, and called her to testify on February 2, 2007.

17. F.L.M. is now 67 years old. She is married; she and her husband have five adult children. F.L.M. worked as a medical assistant for an internal medicine physician for about 12 years, from 1975 to 1988. She worked in the "front office" doing billing and clerical work, and in the "back office" administering electrocardiograms, taking blood pressure readings, and doing diet consultations. F.L.M. is familiar with some medical terms. She is not employed at the present time, but she is a volunteer with the Hemet Police Department.

F.L.M.'s medical history includes a hysterectomy in 1972 that, in her words, resulted in the "absence of [her] cervix." F.L.M. was a Kaiser member from 1997 to January 2007. She disclosed her hysterectomy to Kaiser when she first became a member.

In 2004, F.L.M. was experiencing longstanding problems with diarrhea, and had been diagnosed with irritable bowel syndrome. Her primary physician referred her for a flexible sigmoidoscopy, and she appeared for the procedure with respondent on June 22, 2004. F.L.M. described the procedure as follows:

She was given a sheet of instructions to prepare for the flexible sigmoidoscopy. The sheet called for her to administer three enemas on the day of the examination. She did the enemas on the morning of June 22, before her scheduled examination at 1:30 p.m.

F.L.M. appeared on time for her appointment, but had to wait at least an hour before she was called in to the procedure room. She does not remember respondent apologizing for the delay or telling her that there was an emergency. She was not in any physical discomfort.

When she was called in to the examination room, F.L.M. removed her clothing from the waist down, as directed, and went to the bathroom to urinate. She did not have any diarrhea at the time of the procedure, and she was not experiencing any cramping.

F.L.M. was then taken to the examination table, where she was told to lay down on her left in the fetal position. Torres and respondent were both present. Respondent placed lubricant in and around the anus, and he told her there was redness in the area. Respondent told F.L.M. that he was going to put the scope in, and told her to tell him if it hurt.

Respondent started to insert the scope, and F.L.M. told him that she was having pain. F.L.M. stated that it felt like she was being scratched and irritated, a burning sensation. F.L.M. testified that it is hard to describe the sensation, and she cannot identify whether it was coming from the vaginal area or the rectum. She also felt pressure, and felt like she had to urinate. After she complained of pain to respondent, respondent "started again." F.L.M. told him, "It really hurts." Respondent told her, "I can't go any farther" and terminated the procedure. The whole procedure lasted about a minute. Once she was placed on the examination table, F.L.M. did not get up to go to the bathroom. She did not have diarrhea at all during the procedure, and she did not see any diarrhea on the examination table. Respondent never told her that she was poorly prepared for the procedure.

Respondent told Torres to schedule a colonoscopy, saying either that it was "urgent" or that it needed to be done "as soon as possible." Respondent did not say that there was "no hurry" to do the colonoscopy. Respondent also directed Torres to do a CEA test. F.L.M. knew what a CEA test was for and concluded that she had advanced colon cancer.

F.L.M. observed that both Torres and respondent appeared to be very upset after the procedure. Torres accompanied her on the way out and kept patting her on the shoulder.

F.L.M. knew that something had gone wrong with the procedure, but she did not know what the problem was or whether she had been scoped at all.

F.L.M. returned for her colonoscopy two days later. She remembers that Torres assisted at both procedures, but she does not remember Torres asking her about "desensitivity" in the perineal area, and F.L.M. feels that she is not desensitized in that area. After the procedure, Dr. Wang informed her that her colonoscopy was normal.

About a month after the colonoscopy, Dr. Wang asked F.L.M. to come to his office for a consultation; F.L.M.'s husband accompanied her. Dr. Wang told them that respondent was no longer with Kaiser because of "what had happened," and told them that respondent had inserted the sigmoidoscope in her vagina. Asked at hearing whether she was surprised to hear that, F.L.M. stated "yes and no." She knew the sigmoidoscopy had gone wrong and that respondent had not completed it, but she did not know exactly what had happened. F.L.M. was surprised and appalled to hear that respondent had put the scope in her vagina.

18. Dean Lawlor Rider, M.D., testified as an expert witness on behalf of respondent. He is board certified in internal medicine and gastroenterology.

In Dr. Rider's opinion, respondent inserted the sigmoidoscope into F.L.M.'s rectum, not her vagina. He notes that respondent reported the extensive presence of stool and diarrhea, which would not be present in the vagina. Dr. Rider also notes that respondent reported insertion of the sigmoidoscope to 20 centimeters, which would not be possible in a normal vagina.

Dr. Rider dismisses the evidence that suggests respondent performed a vaginal examination. He states that, without "context," the photographs from respondent's procedure are inconclusive as to where they were taken. Looking at the photographs alone, Dr. Rider testified, it is not possible to determine whether one is looking at colon, vagina, or the back of the mouth. In addition, Dr. Rider asserted, if respondent knew he had inserted the scope into the vagina, he cannot imagine why respondent would have taken photographs, since the purpose of the procedure was an examination of the colon, not the vagina. Dr. Rider believes that respondent's findings on examination are not necessarily inconsistent with Dr. Wang's colonoscopy findings. He states that F.L.M.'s diarrhea could have caused muscle cramping, making the mucosa appear to "narrow down." And while Dr. Wang found no polypoid lesions, Dr. Rider states that "intellectual honesty" precludes him from accepting Dr. Wang's findings at face value; he states that "maybe Dr. Wang missed a polyp – it happens." As for F.L.M.'s testimony, Dr. Rider states that it "solidified [his] opinion" that respondent scoped her rectum, because the feelings that F.L.M. described having during the procedure are exactly the feelings that a patient experiences with a rectal examination. He gives no weight to the testimony of Torres, dismissing her testimony as the observations of "the nurse who said she saw cervix" in a patient whose cervix was surgically removed. And Dr. Rider does not believe that respondent's physician interview shows that respondent scoped the vagina. He believes that respondent's statements were unclear and ambiguous. Dr. Rider stated that,

in his opinion, respondent inserted the scope into F.L.M.'s rectum, even if respondent appeared to state otherwise in his interview.

Dr. Rider testified that F.L.M. should have been given a colonoscopy to begin with, because a colonoscopy is the standard of care for a woman over age 60 who has never had a colonoscopy before. In Dr. Rider's opinion, therefore, it was appropriate for respondent to order a colonoscopy for F.L.M.

Dr. Rider acknowledged that, in a patient whose cervix has been surgically removed by hysterectomy, it would not be possible to pass a sigmoidoscope through the area where the cervix used to be. Dr. Rider acknowledged that the photographs from respondent's procedure could depict F.L.M.'s closed cervical area.

19. The evidence establishes that, on June 22, 2004, respondent inserted the flexible sigmoidoscope into F.L.M.'s vagina and falsely documented that he inserted the instrument into her colon: respondent admitted that he did.

When respondent met with Dr. Chen two weeks after the procedure, he admitted to Dr. Chen that he had scoped the patient's vagina. When respondent met with the board for his physician interview in March 2005, he admitted again that he had scoped the patient's vagina – there was "no doubt about that" – and that he did not chart his mistake because he was too embarrassed to do so.

20. Respondent argues, in essence, that his admissions should be disregarded in favor of his testimony at hearing that he inserted the scope into the rectum. Respondent's argument cannot be accepted, for three reasons.

First, respondent has offered no sound reason to disregard his admissions. Respondent's testimony that he admitted to scoping the vagina only because other people suggested to him that he had done so, is not credible. Respondent acknowledged that he scoped the vagina when Dr. Chen first raised the subject with him; it is not probable that, faced with termination of his employment, respondent admitted to a procedure he did not perform merely because Dr. Chen suggested it. Dr. Rider's characterization of respondent's admissions as unclear or ambiguous, and Dr. Rider's conclusion that respondent inserted the scope into the rectum despite respondent's admissions that he scoped the vagina, suggest that Dr. Rider's opinions are not free from bias.

Second, the evidence corroborates respondent's admissions. Respondent's admissions are corroborated by the testimony of Torres, who stated that she saw cervix and vaginal tissue on the monitor. It is true, as Dr. Rider notes, that Torres could not have seen "cervix," as she testified, because F.L.M. has no cervix. But Torres also testified that what she saw did not look like any colon she had ever seen before, that the images looked like images from a vaginal insertion she had seen before, and that she saw the same images twice. What Torres saw was the closed area where F.L.M.'s cervix used to be, before it was surgically removed.

Respondent's admissions are corroborated by the testimony of Dr. Rider and F.L.M. Dr. Rider testified that, in a patient whose cervix has been surgically removed, it is not possible to insert a sigmoidoscope through the area where the cervix used to be. F.L.M. testified that, after she complained of pain upon the insertion of the scope, respondent inserted the instrument again, and then terminated the procedure, informing her "I can't go any farther."

Respondent's admissions are further corroborated by the inconsistency between his findings and Dr. Wang's colonoscopy findings. The photographs from respondent's procedure are different in appearance than the photographs from Dr. Wang's procedure. Respondent's findings of the "suggestion of several polypoid lesions" and "narrowing down" of the mucosa are inconsistent with Dr. Wang's examination of the colon, which revealed no polypoid lesions and no narrowing. Dr. Rider's opinion that cramps from diarrhea may have caused the mucosa to appear to "narrow down" during respondent's examination is contrary to respondent's admissions that he scoped the vagina, and contrary to F.L.M.'s testimony that, on the day of the procedure, she did not have cramps or diarrhea. Dr. Rider's opinion that respondent's findings are not inconsistent with Dr. Chen's findings, because Dr. Chen "may have missed a polyp," is based on speculation. Dr. Rider's opinion that respondent's pictures are inconclusive because they lack "context" disregards respondent's admissions that he scoped the vagina, and disregards the fact that respondent's pictures and Dr. Wang's pictures look different.

And third, respondent's exculpatory testimony at hearing, which is not trustworthy in light of his prior admissions to Dr. Chen and the board, was also contradicted in every material respect by Torres and F.L.M. Respondent testified that F.L.M.'s procedure was in the morning, but Torres and F.L.M. both stated that it was in the afternoon. Respondent testified that F.L.M. had active diarrhea the day of the procedure, but F.L.M. testified that she did not. Respondent testified that there was stool on F.L.M.'s gown and the examining table, but Torres and F.L.M. both state that there was not. Respondent testified that F.L.M. had to use the bathroom after she was placed on the examination table – "not just before the examination like most patients" – but F.L.M. states that she did not. Respondent testified that fecal matter obscured his ability to visualize where he was, but Torres saw no fecal matter on the monitor and F.L.M. stated that she did not have active diarrhea. Respondent testified that he inserted the scope only once; Torres and F.L.M. both testified that he inserted it twice. Respondent testified that he could have gone farther with the scope, but chose not to; at the time of the procedure, however, respondent told F.L.M. that he could insert the scope any farther. Respondent testified that he did not order the colonoscopy on an urgent basis, but both Torres and F.L.M. testified that he did. The testimony of Torres and F.L.M. was credible and persuasive.[3] Neither Torres nor F.L.M. has a motive to lie about the procedure. Respondent's testimony at hearing concerning his examination of F.L.M. was not credible.

[3] It is acknowledged that Torres and F.L.M. do not agree on whether they had a discussion concerning "desensitivity" in F.L.M.'s perineal area. Their conflicting testimony on this point does not affect the fundamental credibility of either witness.

21. Notwithstanding the evidence that he scoped the vagina, respondent argues that he must have scoped F.L.M.'s colon because he observed stool, which would not be present in the vagina, and because the vagina cannot accommodate insertion of the sigmoidoscope to 20 centimeters. Respondent's report regarding the presence of stool, however, was not accurate. Respondent admitted, and the evidence establishes, that he scoped the vagina, where there is no stool; Torres saw no fecal matter on the monitor, and no fecal matter is seen in respondent's photographs. And it is difficult to be confident in respondent's report that he passed the scope to 20 centimeters, because that finding is incorporated in a report that falsely reports an examination of F.L.M.'s colon. But, accepting respondent's report at face value, respondent stated that he could pass the scope "only to approximately 20 cm." There is no evidence that the scope would not pass to "approximately" 20 centimeters in this patient with a history of a surgical hysterectomy, during a procedure in which the scope was inserted to the point that it would "not go any farther," and inserted to the point that it caused the patient so much pain that the procedure had to be terminated.

22. Respondent's written and dictated chart notes, set forth in Factual Finding 4, falsely document an examination of F.L.M.'s colon, and falsely report findings that respondent did not observe. Relying on Dr. Rider's testimony, respondent argues that he would not have taken pictures if he had known he was in the vagina, because the purpose of the procedure was an examination of the colon. But the issue is not whether respondent knew he was in the vagina when he took the pictures, but whether he knew he was in the vagina when he wrote and dictated his findings. On that point, the evidence is clear: respondent admits that he knew he had inserted the instrument into the vagina but that he was "too embarrassed to write that down."

23. The second amended accusation alleges, and the matters set forth in Factual Findings 8, 11, 14, 17, 20, and 21 establish, that respondent's testimony at hearing concerning F.L.M.'s procedure was not honest in the following respects:

Respondent's testimony that stool prevented him from identifying where he put the scope was not true.

Respondent's testimony that the scope did not slip out of the patient, and that he did not reinsert it into the vagina, was not true.

Respondent's testimony that he did not order an urgent colonoscopy for F.L.M. was not true.

Although respondent admitted in his physician interview that he failed to document insertion of the scope into F.L.M.'s vagina because he was too embarrassed to do so, at hearing respondent denied that he failed to document that fact because of embarrassment, and testified that he thought he was in the colon. Respondent's denial was not truthful.

The second amended accusation alleges that respondent was not honest when he testified that he did not ask Torres to find another member of the gastroenterology department to help him with the scope. The evidence fails to establish this allegation.

24. It was established by the expert opinion of James J. Huang, M.D., that, in performing a vaginal examination of F.L.M., reporting false findings, ordering a test that raised F.L.M.'s suspicion of an obstruction and colon cancer, and exposing F.L.M. to the risks of another procedure, respondent made an extreme departure from the standard of care. It was established by the testimony of Dr. Huang that, while it is appropriate to offer a colonoscopy to a female patient who is over age 60 and has never had a colonoscopy, it is never appropriate to order a colonoscopy on false findings. Dr. Huang did not offer an opinion on whether respondent's treatment of F.L.M. was incompetent, or on whether respondent committed repeated negligent acts in his treatment of F.L.M.

25. Respondent submitted letters of reference from persons who know him well, including a priest, a police commissioner and several medical professionals. The authors praise respondent as a good friend and a competent and responsible physician. The letters do not indicate any familiarity with the facts of this case.

26. Upon the advice of his attorney, respondent attended Phase I of the PACE Program in August 2006. William A. Norcross, M.D., Director of the PACE program, and Peter A. Boal, Senior Program Representative, report that respondent does not have any physical or mental health problems that would interfere with his ability to safely practice medicine, and that he has "an acceptable level of clinical knowledge and judgment to practice gastroenterology."

27. The original accusation sought recovery of the board's costs of investigation and prosecution under Business and Professions Code section 125.3, but the second amended accusation is silent on the issue of cost recovery, and no evidence of the board's costs of investigation and prosecution was offered.

LEGAL CONCLUSIONS

1. The standard of proof applied in this proceeding is clear and convincing evidence to a reasonable certainty.

2. First Cause for Discipline. Under Business and Professions Code section 2234, the Division of Medical Quality may take disciplinary action against a physician who has engaged in unprofessional conduct. Section 2234 defines "unprofessional conduct" to include gross negligence (subd. (b)), repeated negligent acts (subd. (c)), and incompetence (subd. (d)). The evidence did not establish that respondent's treatment of F.L.M. was incompetent, or that respondent committed repeated negligent acts in his treatment of F.L.M. (Factual Finding 24.) Respondent's treatment of F.L.M. was grossly negligent. (Factual Findings 3, 4, 5, 8, 11, 14, 17, 19, 20, 21, 22, and 24.) Cause for discipline exists under Business and Professions Code section 2234, subdivision (b).

3. Second Cause for Discipline. Business and Professions Code section 2234 defines "unprofessional conduct" to include "any act involving dishonesty or corruption which is substantially related to the qualifications, functions or duties of a physician and surgeon" (subd. (e)). Under section 2234, subdivision (a), as that section relates to Business and Professions Code section 2261, it is unprofessional conduct for a physician to make or sign any document "which falsely represents the existence or nonexistence of a state of facts . . . ." Under section 2234, subdivision (a), as that section relates to Business and Professions Code section 2262, it is unprofessional conduct for a physician to create a false medical record, with fraudulent intent. Respondent reported false findings of his examination of F.L.M. (Factual Findings 4, 5, 8, 11, 14, 17, 20, 21, 22, and 23.) Cause for discipline exists under Business and Professions Code section 2234, subdivision (e), and under Business and Professions Code section 2234, subdivision (a), as that section relates to Business and Professions Code sections 2261 and 2262.

4. Third Cause for Discipline. Under section 2234, subdivision (a), as that section relates to Business and Professions Code section 2266, it is unprofessional conduct for physicians to fail to maintain adequate and accurate records relating to the provision of services to their patients. Respondent failed to maintain adequate and accurate records regarding his provision of services to F.L.M. by reason of the matters set forth in Legal Conclusion 3. Cause for discipline exists under Business and Professions Code section 2234, subdivision (a), as that section relates to Business and Professions Code section 2266.

5. Fourth Cause for Discipline. Respondent's testimony at hearing concerning his examination of F.L.M. was dishonest in certain respects. (Factual Finding 23.) Respondent's testimony constitutes additional cause for discipline under Business and Professions Code section 2234, subdivision (e).

6. Of the many legal duties imposed on a physician, none is more fundamental than the duty to accurately report his findings on examination. To avoid personal embarrassment, respondent falsely reported his findings following his examination of F.L.M. To respondent's credit, he was forthright about the procedure in his physician interview. His candor during the interview suggested that his false documentation of F.L.M.'s procedure might have been due to panic rather than dishonesty. No such explanation, however, is available for respondent's testimony at hearing, where he offered an account of F.L.M.'s procedure that was diametrically opposed to his statements in the physician interview, and which was false in every material respect. Although respondent may be capable of practicing medicine in other respects, the evidence establishes that he cannot be trusted to truthfully report his medical findings. There is no choice but to revoke respondent's certificate.

ORDER

Physician's and Surgeon's Certificate No. C14061 issued to respondent Irvin H. Strub, M.D., is revoked.

The authority of respondent Irvin H. Strub, M.D., to supervise physician assistants pursuant to Business and Professions Code section 3527 is revoked.

DATED: March 15, 2007

DAVID L. BENJAMIN
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: IRVIN H. STRUB, M.D. 1109 Deborah Street Upland, CA 91784 Physician's and Surgeon's Certificate No. C 14061 Respondent.	Case No. 09-2004-160393 OAH No. L2005120052 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. David T. Thornton (Complainant) brings this Second Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about July 11, 1952, the Medical Board of California issued Physician's and Surgeon's Certificate No. C 14061 to IRVIN H. STRUB, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2007, unless renewed.

JURISDICTION

3. This Second Amended Accusation is brought before the Division of Medical Quality (Division) for the Medical Board of California, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's

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conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g). . . ."

6. Section 2266 of the Code provides that the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts and Incompetence)

7. Respondent is subject to disciplinary action under section 2234(b), (c) and (d), of the Code, in that he was grossly negligent, repeatedly negligent and incompetent in connection with the care, treatment and management of a 64-year-old female patient. The circumstances are set forth below.

8. On or about June 22, 2004, respondent attempted to perform a flexible sigmoidoscopy on a 64-year-old female patient. Instead of inserting the scope into the patient's rectum, respondent negligently inserted it into her vagina.

9. Respondent knew, or should have known, he placed the scope in the patient's vaginal canal. Thereafter, respondent negligently and misleadingly failed to note this error, and instead negligently and misleadingly documented the suggestion of several polypoid lesions and a narrowing of the mucosa at about twenty (20) centimeters.

10. During the procedure respondent attempted to reinsert the scope into the patient's rectum after it came out, but again was grossly negligent when he reinserted the scope into the patient's vagina.

11. Following the failed flexible sigmoidoscopy on June 22, 2004, respondent nonetheless ordered the patient undergo an urgent colonoscopy. It was performed two days later

on or about June 24, 2004, by a Dr. W. The colonoscopy failed to substantiate respondent's purported findings of his June 22, 2004, procedure.

SECOND CAUSE FOR DISCIPLINE

(Dishonesty and False or Fraudulent Medical Records)

12. Respondent is further subject to disciplinary action under sections 2234(e), 2261 and 2262, of the Code, in connection with his care, treatment and management of a 64-year-old female in that he created a medical record that falsely and misleadingly reported what he had done and found, as set forth in paragraphs 8-11, above, which are incorporated by reference herein as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

13. Respondent is further subject to disciplinary action under section 2266, of the Code, in connection with his care, treatment and management of a 64-year-old female in that he created a medical record that failed to fully and correctly document the procedure he performed, as set forth in paragraphs 8-11, above, which are incorporated by reference herein as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Dishonesty)

14. Respondent is further subject to disciplinary action under section 2234(e), of the Code, in that during his testimony at hearing respondent was dishonest about the circumstances surrounding his performing of the June 22, 2004, flexible sigmoidoscopy by reason of, but not limited to the following:

A. Respondent denied the scope slipped out of the patient.

B. Respondent denied reinserting the scope into the vagina.

C. Respondent denied ordering the colonoscopy be done on the patient in an urgent time frame.

D. Respondent represented there was stool on the screen which prevented him from identifying where he put the scope.

E. Respondent denied asking the attending nurse to find another member of the gastrointestinal department to help him with the scope.

F. Respondent denied admitting he was too embarrassed to document the fact he placed the scope in the patient's vagina, as he stated at his physician interview.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. C 14061, issued to IRVIN H. STRUB, M.D.;

2. Revoking, suspending or denying approval of IRVIN H. STRUB, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering IRVIN H. STRUB, M.D., to pay the Division of Medical Quality the costs of probation monitoring should he be placed on probation;

4. Taking such other and further action as deemed necessary and proper.

DATED: 12/4/06

DAVID T. THORNTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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